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NEW YORK UNIVERSITY PRESS
New York

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The Pelvic Exam and the Politics of Care

[A faculty member] would go down to the public clinic, manually select a woman, say, "You're going to come upstairs and teach the pelvic exam." Not "are you?" or "will you?" "You are." He would completely cover the patient with drapes, including the head. [He would] go into the exam room and the students were probing down this anonymous vagina and roll her out. Then he'd give her money.
—Charles, MD, medical faculty

I like the fact that they're [GTAs] sitting up, that they're able to see what the practitioner's doing and not laying back where they can't see anything. . . . They feel by training young people early on and getting them in the habit of proper communication and touch . . . [and] different techniques that . . . help to make the whole experience . . . less scary . . . [like] you're going to look forward to going to your provider.
—Heather, program coordinator

These two quotations represent two different regimes of practice for teaching and learning the pelvic exam in medical school, one before and one after the introduction of gynecological teaching associates.[1] In the first, Charles, a senior physician, reflects on how the previous generation of medical students at his university were taught the pelvic exam. A woman waiting in a public clinic for perhaps something completely unrelated would be forced to have medical students examine her in exchange for her "free" healthcare. Her subjectivity was removed as her body became reduced to an "anonymous vagina" that medical students would "prob[e] down" in the presence of their instructor; this woman would literally become an object under the medical gaze.[2] In the second quotation,

Heather, the coordinator of a GTA program, reflects on how medical students are taught the pelvic exam today. Instead of an "anonymous vagina" coerced into the exam, well-paid volunteers now use their bodily expertise to train medical students on more than just the most basic components of the exam. These women, in contrast to those in Charles's example, sit up and look their trainees face to face. They teach about communication skills such as offering a verbal warning before you make intimate contact with a patient's genitals. Emotion is never mentioned in Charles's example, though it does show how affects of disrespect toward and dehumanization of patients are cultivated in medical trainees. In Heather's, the patient's emotion is centered in the process of cultivating affects of attentiveness and empathy in trainees: the exam should be "less scary," even to the point of it being something patients look forward to having. There is a distinct ethos of care in Heather's description that is lacking in Charles's.

I argue in this chapter that teaching and learning the pelvic exam in United States medical education has been transformed by feminist practices of care, even as these same practices have been coopted in order to serve the interests of physicians and medical educators. In making this argument, I also demonstrate how the disruptive potential of affect is managed by new strategies of governance in medical education. The background for this chapter is the incidental convergence of several histories: during the 1970s and 1980s, the Women's Health Movement, medical education research, and transformations in biomedicine altered one another's trajectories and changed how the pelvic exam is taught to medical students and, thus, the pelvic exam itself. I use the development of the program at one university as a case study to show how these dynamics played out on the ground, at the same time that large structural forces were operating at the national (and to a lesser extent the international) scale to challenge existing practices. As I follow these historical shifts, I trace what changed and what stayed the same in teaching and learning the pelvic exam. I claim that the way that these three histories converge on the pelvic exam demonstrates the transformations that are possible to the material practices of medical education through feminist activism—and those that remain untenable given structures of knowledge and power in biomedicine.

In particular, I follow transformations with regard to practices of care in clinical medicine. The two quotations with which I opened the chapter

demonstrate two very different forms of relating to patients in teaching and learning the pelvic exam. The physician in Charles's example probably did care about patients at his clinic inasmuch as he felt it was his mission to treat and prevent disease. But he certainly did not demonstrate the kind of care for patients that Heather's GTAs do in their commitment to making the pelvic exam if not something "to look forward to," at least "less scary." Here, I use the concept of assemblage to analyze how the politics of care have been articulated in the pelvic exam across its history. What makes the concept of the assemblage useful is that it describes both the "hanging together" of diverse, multilayered elements, as well as the opposite: the continual "lines of flight" or pulling apart of these elements.[3] I consider the pelvic exam as an assemblage in order to account for biomedical discourse, the materiality of bodies and tools, the social relations within the encounter, and so forth, all coexisting within this fraught practice. Throughout this chapter I draw attention to what components of the assemblage are being reworked in any given situation in order to trace how care has been worked into the pelvic exam.

I am informed by the feminist work in science and technology studies on care as an affectively charged "attachment or commitment to something" (de la Bellacasa 2011:89–90). In these literatures, care invokes notions of material doing, by which I mean that caring involves direct engagement with the material world, with its tools and practices, as it pertains to something that a person or group cares about.[4] Thus, throughout this chapter, think of care when I discuss it as an affective engagement in practice. To care about someone or something is to invest some part of oneself emotionally, to be attentive to and engaged with the object of one's care. In this way, care has had to be assembled into the pelvic exam through feminist actions. And yet, due to the standardizing and objectively oriented goals of medical education and, more broadly, biomedicine itself, feminist means of caring can always only be partially assembled into the pelvic exam. I identify simulation as the key technology through which feminist practices of care are incorporated into medical education and show how caring practices bump up against structural forces that dictate who, what, and how care can be enfolded into biomedicine.

Moreover, to care is to make choices about what else one is *not* caring about. Care "is a selective mode of attention" (Martin, Myers, and Viseu

2015:627) in that by making space for some issues, people, or things, it excludes others. This raises the issue of a *politics* of care. "Practices of care are always shot through with asymmetrical power relations: who has the power to care? Who has the power to define what counts as care and how it should be administered?" (Martin, Myers, and Viseu 2015:627). In this way, care cannot be thought of as always innocent, always positive, always beneficial for all. Rather, care "organizes, classifies, and disciplines bodies[;] . . . care makes palpable how justice for some can easily become injustice for others" (Martin, Myers, and Viseu 2015:627). The politics of care are "entangled in the complex devaluing and valuing of care, even as care is repeatedly promised as a source of potential emancipation and alternative technoscience" (Murphy 2015:724). Thus, when analyzing practices of cares, scholars must be attentive to (should I say *care*ful of?) easy promises of liberation through the incorporation of care and must instead constantly be aware of the exclusions and other arrangements that make some lives less livable. As I show in this chapter, the politics of care in teaching and learning the pelvic exam are entangled in the complicated histories of exclusion between biomedicine and gender, sexuality, and race. This links to my larger argument in this book about the ways in which affective capacities (of which care is one) are harnessed and manipulated by governance strategies in medical education: caring about patients in the way that is being taught reinforces medical authority across an uneven terrain of power in an era of corporatized healthcare.

The Biopolitics of the Pelvic Exam

The pelvic exam is a collection of gestures, actions, tools, words, and bodies of knowledge—both scientific and experiential. Each one of these components is imbued with history—not only the physician or patient's own experience, but the social and historical contexts that shaped it as it came into being. What arose as a routine technology for the biomedical disciplining of gendered and racialized bodies has become a collaborative practice shaped by contemporary discourses about the physician-patient relationship. Care has been incorporated into or absent from it in complex and contradictory ways. Understanding where the pelvic exam comes from is crucial to understanding the forms of protest surrounding it and its continual modulation through the interventions of medical educators and patient health movements.

The pelvic exam's troubling history is rooted in racist and (hetero)sexist exploitation of bodies. While midwives have long examined pregnant people's bodies and sex workers have historically been subjected to physical inspection in the name of hygiene, the pelvic exam as a biomedical practice involving visual, manual, and speculum examination arose in the mid-nineteenth century with the nascent medical specialty of gynecology (McGregor 1998). Gynecology emerged out of obstetrics, as physicians increasingly identified diseases of the reproductive system or injuries due to difficult labor and delivery. Its foundational tool, the speculum, exemplifies its problematic origins (Barker-Benfield 2004; Snorton 2017; Washington 2006). French midwife Marie Boivin and French physician Joseph Claude Anselme Récamier are both credited with developing the bivalve speculum at about the same time, in 1825 (Ricci 1949). However, the speculum spread in the European medical communities in part because of public viewings at hospitals involving sex workers. Curious members of the medical community would watch as sex workers were forced to undergo public speculum examinations (Lee 1851; Ricci 1949).[5]

In the United States, the "father" of modern gynecology, J. Marion Sims, invented the forerunner of the "duckbill" speculum used today by exploiting the bodies of enslaved Black women (Owens 2017; Snorton 2017; Washington 2006). Sims was a pioneer in gynecological surgery, particularly of fistulas, which are vaginal openings or tears that allow urine or fecal matter to leak into the vagina. They were—and still are—debilitating conditions that need treatment, yet the methods Sims used demonstrate medicine's history of racist exploitation in the name of progress. Sims performed experimental surgeries on enslaved women without using anesthesia, even after anesthesia became routine. This was because Sims, like many, believed that Black people do not experience pain the way that white people do as a result of the brutalizing conditions of their enslavement (Owens 2017).[6] From these experiments on Lucy, Anarcha, Betsey, and almost thirty other enslaved Black women,[7] Sims developed the forerunner of today's speculum out of two spoons used to hold the open the vagina. The speculum thus allowed physicians better access to the interior organs of the body and became a material tool for expanding biopolitical control over certain kinds of bodies.

During the twentieth century, the pelvic exam became more commonplace as the relationship between medical authority and gendered (and racialized) bodies changed. The routine pelvic exam rose to prominence in the early part of the century with the invention of the Pap smear and its promotion through public health agencies (Casper and Clarke 1998; Löwy 2010). This tool served to expand the reach of biopolitics by coding reproductive bodies as always already at risk and in need of medical surveillance. During this time, the pelvic exam shifted from being about locating disease toward the maintenance of health via regular screening. With this shift, this form of discipline became about more than health—it also became about reinforcing (hetero)sexist discourses about reproductive bodies.[8]

During the middle part of the century—the so-called Golden Age of Doctoring—the premarital pelvic exam was made compulsory both by social norms and, in most states, by law.[9] During this exam, which was ostensibly about reproductive health, a young soon-to-be-married (and presumably virgin) woman was examined so that a (man) physician could "gently" instruct her about heterosexual penetrative sex in preparation for her wedding night. Such instruction involved both verbal remarks about sexuality and reproduction and vaginal penetration with a speculum to ensure that the bride-to-be was capable of having sex with her husband in this way. Influenced by Freudian theories of psychosexual development, physicians believed that a vaginal orgasm inside of marriage was the only form of healthy sexuality for adult women. By instructing women via the pelvic exam, physicians could therefore protect the sanctity of the (white, middle-class) nuclear family by ensuring a proper sexual order. These pronouncements were, of course, tied to racialized and heterosexist understandings of "normalcy": women of color and lesbians were discussed in the medical literature of this time only as pathological (Lewis 2005, 2010). In addition, while white women were "gently" instructed on proper womanhood including becoming mothers, poor women and women of color were targeted for coercive sterilization (Briggs 2003; López 2008; Roberts 1999). Thus, in this way, the pelvic exam has come to serve as a routine medical technology that shapes the gendered and racialized experience of having a body coded as female.

It should not be a surprise, then, that the pelvic exam was taught in such a manner that dehumanized its patients. It was also imbued with

the expectation that women deserved to be in pain or could tolerate it without complaint—while those who could not were considered psychologically abnormal. For example, a medical textbook commonly assigned in the 1970s "tells medical students that 'mature' women don't react to pain": if "she is not 'relaxed' during a pelvic examination with an 'unlubricated speculum,' she might also be referred to a psychiatrist" (Weiss 1975:24–25).[10] Writing from a different point of view in the mid-1970s, a woman physician noted of her experience in medical school: "Coupled with these slights to female patients in medical school . . . are the attitudes and assumptions about 'woman's place' that color the doctor-patient relation. . . . One lecturer said, 'The only significant difference between a woman and a cow is that a cow has more spigots'" (Howell 1974:305).

The subjects of medical students' first introduction on the pelvic exam reinforced these messages about gender, the body, and medical authority. Prior to the gynecological teaching associate model, medical students first learned how to perform a pelvic exam on clinic patients (sometimes under anesthesia), plastic models, sex workers, or cadavers (Godkins et al. 1974; Kapsalis 1997; Kretzschmar 1978). As former GTA Terri Kapsalis argues:

> By using anesthetized women, cadavers, or plastic models as pelvic exam subjects students are being taught that a model patient (or patient model) is one who is essentially unconscious or backstage to the performance of the pelvic exam; she should be numb to the exam, providing no feedback and offering no opinions. . . . Passive and powerless female patients are considered ideal "participants" in the learning process. In addition, students practicing on essentially silent and lifeless models are learning that the manual skills associated with completing a pelvic exam are more important than the fundamental skills needed to interact with the patient. (1997:66)

These observations highlight several aspects of the practice of teaching and learning the pelvic exam prior to the advent of GTA programs. The pelvic exam involved an affective engagement characterized by a distinct *lack* of caring by the physician for his patient. Caring about the population via cervical cancer screenings and the management of

appropriate reproduction was considered sufficient. Little care was taken for the patient (or the physician's) experience of the exam. This reflected a wider affective economy in which care was valued according to paternalistic standards in medicine: physicians were encouraged to care about patients in the abstract but strongly discouraged from developing emotional attachments to any patient in particular. One was to care for one's patients as a father does his children: through the provision of mandates that were in their best interest.

This all changed with the advent of the Women's Health Movement in the 1960s and 1970s, when some activists no longer accepted the existing practices of reproductive healthcare. "The Women's Health Movement" is a label that has come to be used by scholars to describe multi-sited rebellion by activists with varying goals and orientations toward mainstream medicine (Davis 2007; Kline 2010; Morgen 2002; Ruzek and Becker 1999; Zimmerman 1987). GTA program coordinator Martha described the kind of caring relationship valued prior to the advent the Women's Health Movement and activists' effects on the pelvic exam:

> I'm from the era [when] women were examined like flat on their back with a drape over their knees, and it was thought that . . . neither of us will talk, or I'll ask you what you did on your last vacation because we're both kind of embarrassed . . . so let's just pretend it's not happening. And women were also patronized. . . . Pat them on the knee and say, "Oh, don't worry about a thing, dear, I'll take care of you." And so . . . the rebellion and the women's movement, women were taught . . . tear that drape off their knees and sit up and say, "Talk to me face to face!"

In this model, women were to be taken care *of*, not cared *for* by an authoritative physician.[11] As Martha describes, the very material and spatial arrangements—flat on her back, drape over her knees preventing eye contact—reinforced this relationship. Any emotions experienced on either side of the encounter were to be quashed immediately. But the rebellion of the Women's Health Movement challenged these practices and *at the same time* the (lack of) a caring affective engagement between physician and patient. The movement targeted the material and technical practice of the pelvic exam in order to rewrite the ways in which

physicians and patients interacted.[12] In short, it focused on practices in order to transform how physicians cared for—and about—patients.

Feminist activists in the Women's Health Movement were able to take on reproductive healthcare due in part to the emergence of self-help clinics and collectives. In such spaces, activists practiced pelvic exams on themselves and on one another in an effort to pry the tools of reproductive healthcare out of the hands of physicians (Morgen 2002; Murphy 2004). Activists taught each other how to perform abortions and treat vaginal infections themselves. Armed with this knowledge, feminists turned to mainstream medicine and demanded that physicians learn "to treat her [the patient] as a human being and not as an object" (Norsigian 1975:6). They argued that how medical students learned the pelvic exam laid the groundwork for how they would later treat women (Kapsalis 1997; Kline 2010; Norsigian 1975; Weiss 1975). These pronouncements politicized the pelvic exam, made it a matter of biopolitical contention. For example, feminists claimed that the way the pelvic exam was taught was dehumanizing, as it is in the above example where a physician is to refer a woman to a psychiatrist if she complains about discomfort when an unlubricated speculum is inserted into her vagina. As we have seen, they also pointed to how learning the exam on a passive woman lying flat on her back reinforced the idea that women lack agency or should be made to feel vulnerable. Likewise, feminists argued that use of clinic patients taught medical students that especially poor women of color deserved less respect than other women—an argument linked to critiques in feminism and racial justice projects of coercive sterilization as an abuse of medical authority. Finally, feminists were critical of the hiring of sex workers and of the belief that only "that kind" of woman (sexually amoral, sexually saturated) would willingly let strangers examine her, as well as the assumption that sex workers would be passive and compliant. Feminists argued that such a practice reinforced masculinist ideas of women as docile sexual objects, lacking agency and available for their use and disposal.[13] It is important to note that these activists did not reject the need for pelvic exams. Instead, they appropriated the tools of biomedicine and reworked them to fit into feminist models of care being developed in self-help clinics.

Thus, prior to the 1970s, the pelvic exam was a routine form of medical surveillance that sought to manage the health of the population

through cervical cancer screenings and the instruction of white middle-class women in their proper roles as wives and mothers. This made it (and still makes it) a form of biopolitical power targeted toward the gendered and racialized body. However, the way the pelvic exam is practiced has changed quite dramatically. No longer are patients always positioned completely flat on their back, for example, or patted on the knee and told they'll be taken care of by a man in a white coat. Nor do medical school lecturers routinely and openly compare women to cows and recommend forcing specula into (understandably) recalcitrant vaginas; rather, great care is often taken to emphasize the importance of the patient's physical comfort and emotions. This transformation occurred in part due to the efforts of feminist activists.

Initial Collaborations and the Rise of Simulation

In the 1970s, feminist activists and a handful of medical educators began to reconsider ways of teaching and learning the pelvic exam in medical schools. Within biomedicine, medical school faculty became critical of the current models of teaching for three main reasons (Kretzschmar 1978). First, they were exploitative of the patients involved since these exams were purely educational and not for the health benefit of the patient. Second, students were anxious and unable to communicate freely with the instructor because of the patient's presence. Third, the patient was not able to provide detailed feedback to the student as to whether the proper organs had been palpated (i.e., medically examined). These critics tended to align themselves with the growing field of medical education research, which at the time was beginning to consider and develop standardized tools for assessing medical student performance, a story I tell in chapter 2. While medical educators were increasingly critical of the pelvic exam, they were also confronted by challenges from the Women's Health Movement.

The Women's Community Health Center provides one of the most prominent examples of an early collaboration between feminists and medical educators. In 1975, feminist activists embarked on a new way of teaching the pelvic exam when they were approached by women medical students at Harvard Medical School (Bell 1979; Editorial Submission 1975; Kline 2010). This first protocol involved women serving as

pelvic models while a physician taught the students. Although this was satisfactory to the physicians, the women volunteers felt that they were being exploited. In response, these women formed the Pelvic Teaching Program (PTP), which recruited community members to teach the pelvic exam. In this second protocol, two women paired up to teach the exam while the physician remained a silent observer. This was a more agreeable model to the feminist activists, but an article about this teaching protocol that was published in *HealthRight* generated controversy. On one hand, some feminists saw them as an empowering way to have women teach medical students, which would ultimately challenge the dehumanization of patients during the exam. On the other, some activists saw how easily these programs could be coopted and lose their radical potential. Such critics recognized the institutional power of biomedicine to absorb challenges to its financial and social interests. "Teaching medical students ways to improve the pelvic exam for women was taken by [physicians] as a technique of managing their 'patients'" (Bell 1979:14). In their concerns about cooptation, activists thus identified a key phenomenon that would shape whether and how feminist politics of care could be incorporated into teaching and learning the pelvic exam. It had to do with the ways in which members of the medical profession could use feminist practices to meet their own interests. As a result, the collective strongly encouraged other women not to participate in similar programs without the support of a feminist collective behind them. These concerns about cooptation foreshadowed how GTA programs would evolve during the 1980s and point directly to the argument I make in this book: attending to emotion by generating affects of care and empathy is a strategy developed by medical education for managing patients.

The Women's Community Health Center developed a third protocol in order to address concerns over cooptation and depoliticization. This new protocol included several changes that addressed "hierarchy, sexism, fragmentation of learning skills, profit, and division between provider and consumer" (Bell, 1979: 12). The changes included (1) limiting the sessions to only women participants (and thus excluding men) in order to foster reciprocal sharing and challenge sexism in medicine, (2) inviting other hospital personnel to challenge physicians' dominance and the gap between provider and patient, (3) continuing the sessions

over three or four separate occasions to foster critical discussion, and (4) increasing the cost from $25–$50 per session to $750 for all four sessions. Even though the group was approached by multiple medical schools, the protocol was not adopted by any. The reasons provided to the PTP were that the program was too expensive and excluded men, who medical faculty felt were most in need of such training. Thus, feminists were able to bring their political practices into the medical school so long as they followed the rules of the game. When they attempted to challenge basic tenets of medical power, they were unsuccessful.

Feminists in the PTP blamed the failure of their new protocol on the rigidity of medicine while also identifying a key history that would, in other medical schools, be the link between feminist politics of care and medical education: that of simulation. The members of the PTP were unaware when they began working with Harvard Medical School about experiments at other medical schools that use trained laypeople, known as simulated patients, to teach and evaluate clinical skills (Bell 1979; Kline 2010). Simulated patients emerged at other medical schools as a technology that that could effectively manage the threat posed by the Women's Health Movement's politicization of the pelvic exam by enclosing feminist demands and techniques within a system of medical expertise. Through simulated patients, medical educators could turn the relational experience between a physician and a patient into a standardized, measurable object, a history I discuss in more depth in chapter 2. Thus, while the third protocol of the PTP "confronted basic power relations and current assumptions about the goals of medical education," other ways of crafting GTA programs "fell within the acceptable range of innovations, exemplified by the 'Simulated Patient' programs" (Bell 1979:12).

The use of simulation in medical education has a long history, dating back to at least the mid-sixteenth century in Europe, where midwives practiced their delivery skills on a basket-work frame covered in oilskin (Buck 1991).[14] During the 1960s, physicians began experimenting with the use of live people to simulate clinical encounters (Barrows and Abrahamson 1964; Wallace 1997). Using simulated patients allowed medical students to come "close to the truth of an authentic clinical encounter . . . without actually being there" (Wallace 1997:6). This coincided with a shifting ethical terrain in the 1960s and 1970s, when issues regarding informed consent and the exploitation of patients in service

of furthering medical knowledge came to the fore. The use of simulated patients offered one solution: "The student can experience and practice clinical medicine without jeopardizing the health or welfare of real, sick patients" (Wallace 1997:6).

During the 1960s and 1970s at the University of Iowa, Robert Kretzschmar and his colleagues began experimenting with different models of teaching the pelvic exam. Kretzschmar disliked plastic models because they "lack authenticity . . . compared to the student's first encounter with a live patient," but using a patient was problematic, too: the "patient was exploited by the teaching system, as student examinations . . . do not contribute to patient care" (1978:367). The traditional method of teaching also did not address the interpersonal skills involved in performing the exam. At first, Kretzschmar and his colleagues recruited a nurse so that their students could practice the pelvic exam on a live person. However, she provided minimal feedback and her face remained draped to protect her privacy. By the 1970s, Kretzschmar was inspired by work with simulated patients and started a pilot program to recruit women to simultaneously teach the exam and be pelvic models.

Kretzschmar attributed the success of his program to the type of women he hired to work. His group of GTAs were six young women recruited from his university who were all "working toward or have received advanced degrees in the behavioral sciences" (Kretzschmar 1978:368). This made them qualified teachers. In addition, all were involved in some fashion with feminist health activism. Kretzschmar described the activist orientation of these GTAs as important to the work since they were concerned with "learning what it is to be a woman, exploring her own anatomy and physiology, and coming to terms with her sexuality, her attitudes, and her role in life" (1978:369). Hence, these women were comfortable with teaching and talking about the exam. In addition, Kretzschmar believed that these GTAs added "sensitivity and humanism" (1978:369) to the encounter. In this way, Kretzschmar used simulation as a technology that could both meet the needs of medical education *and* enfold some of the feminist practices of care into the pelvic exam. As he noted, "Rather than applying their skills elsewhere, whether it be through free medical clinics of women's health centers, the [GTAs] prefer to work within the existing system" (Kretzschmar 1978:368). By emphasizing the importance of these women's involvement in feminist health activism,

Kretzschmar seems to suggest that their politicization of the pelvic exam makes them amenable to reshaping the practice of the pelvic exam *within* the existing biomedical establishment. Unlike the PTP, Kretzschmar's program fit neatly into the "range of acceptable innovations" that Susan Bell (1979) criticized in her write up of the third protocol. This distinction also highlights the diversity of positions in the Women's Health Movement and their orientation toward biomedicine: some were cautiously optimistic about what they might be able to change in medical practice while others took a firmly antiestablishment approach.[15]

Thus, feminists were able to politicize the pelvic exam during the 1970s, but they were unable to sufficiently challenge the core tenets of biomedicine. Their concerns about how medical students learned the pelvic exam became assembled with medical educators' concerns as the practice of the pelvic exam passed out into the Women's Health Movement and back into medical schools. The key practice that allowed for this assemblage was simulation. As Adele Clarke and Joan Fujimura (2014) have shown, medical technologies must be made and "tinkered with" to make them into the "right tool" for the job. Technologies are adopted and modified by expert actors in order to make them into solutions for problems, which are themselves produced by social actors. Simulation emerged as the "right tool" for teaching and learning the pelvic exam through the actions of medical educators appropriating some aspects of feminist activism. Simulation is produced through expert discourses and practices. Its effects can be quantified and measured. Furthermore, simulation emerged as the right tool for the job because it could be made to capture the unruly forces of affect at work in teaching and learning the pelvic exam—for medical students, faculty, and patients. Put another way, through simulation, feminist practices of care could be brought into biomedicine without directly challenging its political and economic power.

Reassembling the Pelvic Exam at the University of Illinois at Chicago

I turn now to a case study to explore how the pelvic exam was reassembled during the 1980s out of interactions between feminist activists and researchers in medical education. The process of reshaping how medical students learned the pelvic exam reassembled bodies, affects, subjectivities, interactions between physician and patient, disciplinary practices, and professional social behaviors. I focus on the University of Illinois at Chicago (UIC) for three key reasons. First, the development of the GTA program at UIC is richly documented through scholarly publications and private archives. The program is quite representative of the processes and factors that led to the widespread creation and adoption of GTA programs. Second, UIC is home to one of the oldest, most well-established, and most influential centers devoted to medical education research: the Department of Medical Education. As such, it was where many of the key figures publishing the earliest accounts of GTAs came from. Third, Chicago was home to a prominent community of feminist health activists. The underground abortion network Jane was based in Chicago before *Roe v. Wade* legalized abortion access. The Emma Goldman Health Center—which is a key site in the story I tell here—was a flourishing women's self-help clinic that sought to raise women's consciousness about their health and bodies.

The first incarnation of the GTA program at UIC came at the very beginning of the 1980s when a group of medical students approached the Emma Goldman Health Center to prepare a workshop on the pelvic exam. It is significant that medical students themselves—rather than medical educators—first demanded change. According to my interviews, the impetus for the programs at two of the three medical schools I studied was a woman medical student.[16] This was at a time when large numbers of women were entering medical schools: whereas women made up 9.6 percent of medical students in 1970, the figures rose to 20.5 percent in 1976, 26.5 percent in 1981, and 32.5 percent in 1985 (AAMC 2016). Such a major demographic shift created instability in medical education, as women had begun to question the "boys in white" culture of medicine. In addition, while the widespread Vietnam War era protest of the 1960s had dissipated (Altbach and Cohen 1990), its effects lingered in medical schools. Commentators remarked on the change in the medical student body in the 1970s and 1980s, as students became more skeptical of the status quo and demanded more intensive socialization (Ebert 1986; Fox 1979).

Sally, one member of the group at UIC, described her motivation for seeking out help from the Emma Goldman Health Center:

> There was a . . . limited national movement . . . on the part of medical students in response to the Women's Healthcare Movement . . . to train more sympathetic, knowledgeable, and sensitive healthcare providers. So it was really a feminist sensibility of trying to train more appropriate healthcare providers that led [us] to emulate what was happening at a couple of medical schools in the country.

According to Sally, the students had learned about these other schools through student meetings at AAMC conferences. A volunteer from the Emma Goldman Health Center talked to the students about "the impact of the exam and how to do it in a thoughtful [manner], and then she allowed us to perform an exam and gave us feedback." The funds for this program came from the students involved. The source material—the "how to" of the pelvic exam—came from the Emma Goldman Health Center and feminist practices such as self-exam. It included more than just the actual mechanics of the exam: it also stressed how to talk to a patient and appreciate the patient's perspective during the exam, which is an affective component of care that became important to the later program.

However, this initial pairing of medical students with the Emma Goldman Health Center demonstrates some tensions that would run through the program. As historian Wendy Kline (2010) shows, there were longstanding political tensions among feminists due to differences in their orientation toward institutions. Members of the Emma Goldman Health Center originally took an oppositional stance toward the institution of medicine and refused to cooperate with physicians. More mainstream liberal feminist organizations such as the Chicago Women's Health Center and Planned Parenthood (the latter of which would provide activists for GTA training later on in the 1980s) were more amenable; in fact, according to Kline, as the Emma Goldman Health Center faced financial and staffing challenges, its members increasingly worked with the Chicago Women's Health Center and "even a group of young feminist OB-GYNs" (2010:82) at a nearby hospital. This also had effects on the racial politics of the program. Given how diverse and historically

segregated Chicago is, Kline's analysis demonstrates that centers that did not explicitly center race in their missions tended to serve the interests of white women. This is significant because, while consciousness-raising groups were internally homogenous (Murphy 2012), self-help gynecology was not specifically the domain of white women (Morgen 2002; Nelson 2011). Self-help gynecology and self-exams were also important for Black Panther health activism and their community clinics (Nelson 2011). One activist, Norma Armour, even detected cervical cancer by performing her own Pap smear. However, while Black Panther community health clinics invited the flow of experts and tools *out* of biomedicine, they focused more on radically transforming structures of care, rather than on working within institutions to move experts and tools back *in* to biomedicine. For women in the UIC GTA program, working with and within institutions formed a more central component of their activism. I have no reliable data on the racial makeup of this group, but all of the members I was able to interview are white women. Efforts to recruit more women of color were unsuccessful, a topic I return to this issue later in the chapter.

The first workshop at UIC was only for the students who organized it, but eventually the students approached the administration and asked to make their program part of the curriculum. Sally was also pursuing a master's degree in Public Health at the time and decided to compare students who had gone through the program to those who had not in order to determine the program's impact. According to Sally: "That's the data that we used actually to propose this curricular change to . . . the medical school powers that be" and show that the program "would produce more capable and competent clinicians." The school ultimately accepted the proposal. Sally described students' initial reaction to the program as positive: "Most medical students were incredibly supportive and happy to have it because it really reduced the anxiety of doing your first pelvic exam." In this way, the feminist goal of caring for patients by making them feel comfortable aligned with the goal in medical education of reducing medical students' anxieties in order to foster their ability to learn.

Another important figure in the development of the program at UIC was MD physician Charles R. B. Beckmann. After a varied educational career, Charles chose a surgical specialty but quickly discovered that he

preferred patient care: "I think that a key piece of medicine is hearing the patient and gaining the patient's trust. [For me, medicine is] not the money or prestige. It's about the joy of taking care of patients." One of Charles's earliest driving concerns was the importance of taking a good clinical history from a patient in order to direct the physical exam. As a gynecologist, his focus became the pelvic exam.

> It was a skill that if I watched people do it . . . I discerned a tremendous difference in the way they did it and the kind of information they got back. . . . And it had to do with, one, how they did it physically, and two, how they communicated, the level of trust the patient had, the patient being able to relax.

It is this observation that runs through the development of the program at UIC: the connection between style of practice and achieving the desired result. This observation also demonstrates an assemblage between the goal of making patients feel comfortable and empowered, as championed by the Women's Health Movement, and the goal in biomedicine of locating the truth of disease in the body through examination. Cultivating an affective stance of care toward the patient that would evoke trust, and thus relaxation, and would allow a physician to better find pathology on the patient's body. Charles's work then was central to plucking out from feminist politics the aspects of care that could be reassembled into the pelvic exam without challenging the core tenets of biomedicine.

Charles had a colleague who was running a GTA program at another university. This colleague introduced Charles to the GTAs and Charles spent time talking with them to learn about their motivations, their working conditions, and the ways they taught the exam. Interestingly, he also asked them their perspectives of gynecologists. In our interviews, Charles expressed an interest in finding out from the GTAs he worked with why women might dislike or distrust gynecologists so that his protocol for teaching the pelvic exam could correct these issues. He wanted to make physicians into likeable and trustworthy service providers. As he worked on the GTA program, Charles began to understand its implications for how medical students learned to build relationships with their patients. "I came to think that the . . . GTA session taught more

about things that were happening outside of the pelvic [exam] than . . . inside the pelvic [exam]: . . . respect the patient, real understanding of partnership, real understanding of trust." While Charles's personal goals aligned with creating a better experience for patients by making providers more trustworthy, these efforts mapped onto larger challenges for the medical profession posed by the Women's Health Movement. Whether intentionally or not, creating more likeable physicians allowed the medical profession to re-secure its authority over reproductive healthcare.[17]

The timeline and exact process of how this happened is unclear, but at some point before or after his visit to his colleague's program, Charles became aware of what the medical students at UIC were doing. Charles himself doesn't remember how he became aware of it. According to Sally, Charles took over the program while she ran it as a resident under his authority. I suspect that Charles's identity as an experienced physician and a man lent more credibility to the program than Sally, who, as in many similar cases, received no formal credit for her contributions to the program. Her name appears nowhere in the publications of this time, although there is an obscure reference to the "programme founder" or "doctor founder" (Beckmann et al. 1988:125) interviewing potential GTAs in a published article.

With support from the chair of the Department of Obstetrics and Gynecology, Charles continued the program, working with Sally and an expanding group of GTAs drawn from the medical students' original workshop and their peer networks. The GTAs, "ordinary citizen with special knowledge and expertise" (Beckmann et al. 1988:128), were hired as contracted instructors. Charles's involvement in the program at this critical moment highlights the omnivorous ability of biomedical knowledge to absorb and refashion challenges to it. As the GTA program moved away from the early feminists' control and more into the control of medical education, its politics changed. For example, among the qualities that Charles looked for in potential GTAs were: "normal anatomy and the ability to relax sufficiently to allow easy examination . . . high intelligence, good verbal skills, commitment to better instruction for medical students and doctors in these skills, and personal maturity and emotional stability" (1988:125). The emphasis on normal anatomy and emotional stability is particularly evocative, given the gendered and racialized ways in which medical discourse

constructs the female body in the pelvic exam. Normal anatomy meant that the body of the GTA had to mirror what medical students would learn from the anatomical atlas, while emotional stability raises the specter of the hysterical woman whose body is "thoroughly saturated with sexuality" (Foucault 1990:104).

The initial protocol was developed out of conversations among Charles and the GTAs: "Many, many, many hours sitting together talking about their experiences, frustrations, their experiences with friends and what they thought was wrong, what they thought was right." Charles cites as an example what had been a common practice of calling the woman patient a pet name like "honey" or "sweetie": "It was taught in many places that was a way to help a woman relax. Well, it's just the opposite for most women. And it certainly is degrading. [To] a man you wouldn't say, 'Honey, bend over. I want to stick my finger up your butt.'" The GTAs in this early program motivated Charles to address these commonplace practices that resulted in such demeaning experiences. This linked up with Charles's professed interest in understanding how style of practice was related to health-related outcomes such as being able to identify early signs of pathology. And certainly, such a culture of casual sexism contributed to women seeking out alternatives to mainstream biomedicine. By addressing practices that drove women away, medical educators like Charles could reestablish medical authority. In this way, women's feelings about the exam and about physicians had to be addressed and modulated through new types of expert practices.

This goal mapped on to those that feminists also held. Ruth, who had been a GTA at the time, told me, "I really wanted to get into the eye of the storm, to train these motherfuckers [*laughs*] on how to do this right and how to get the information that they needed from their patients so that they could formulate the proper care diagnosis." Likewise, Jaclyn said:

> I hope in some ways it was a humbling experience . . . [to] counter some of the . . . arrogance that medical students . . . are . . . trained to have. I don't believe they come in to school with that. . . . They were . . . trained to have a certain degree of authority and that somehow authority leads to good healing. . . . I think the experience of having somebody who you're examining . . . in a very kind of intense way . . . hopefully opened them up to the idea that that these were people with knowledge and experiences and things that they could potentially learn from. . . . And hopefully it would lead to more respect and closer communication with their patients.

A few other GTAs who were working in the early to mid-1980s echoed a similar sentiment about their motivation for doing the work. Early GTAs like Ruth and Jaclyn felt that training better physicians would improve reproductive healthcare in the long run.

Publications about the program from this time emphasize the feminist orientation of the GTAs and espoused it importance for the program's success at achieving its goals (Beckmann et al. 1988:125). These women's comfort and experience allowed them, in Charles's view, to be ideal teachers and work well with students. He describes treating them as authorities regarding their own experiences: "They had a very strong sense of autonomy, which I . . . am sincerely supportive [of]." This once again highlights the kind of feminist activism that was involved in creating GTA programs:

> The [GTAs] are, in part, attracted to this ambiguous situation because they see it as a way of having positive influence on the training of doctors while not becoming incorporated within the medical education establishment which they may perceive as chauvinistic. The feminist orientation of the [GTA program] is thereby preserved without constraints imposed by the academic organization. (Beckmann et al. 1988:128).

Some feminists might be skeptical about the institution, but they were still willing to work within it to challenge the provision of reproductive healthcare.

The GTAs and Charles worked together on how to teach the skills of the pelvic exam to the medical students. One aspect of this preparation was a great deal of practice with the manual aspect of the exam, especially the speculum insertion, so that the GTAs could develop embodied knowledge about what a proper exam felt like. "And so one of the things we practiced is the women doing the teaching knowing what it felt like to have the speculum not far enough in and far enough in." What Charles learned from these practice sessions with the GTAs ultimately went into his textbook on the exam: "We learned a lot about how does it [the speculum] fit? Not just the obvious things, like warming the speculum,

picking the right size speculum. . . . You need to be careful that you insert the speculum at the right angle. . . . It's not perpendicular to the floor, but it's tilted upward slightly." This contrasts starkly with previous techniques for performing the pelvic exam, in which a patient who complains about the speculum insertion is to be referred to a psychiatrist. What is striking about these techniques as well is that they are taken almost directly from the Women's Health Movement. A 1976 document from the Women's Community Health Center, "How to Do a Pelvic Examination," describes exactly the same method for inserting a speculum.

Similarly, Charles learned to be mindful of the appropriate angles when performing the rectovaginal exam, which involves inserting the middle finger into the rectum and the index finger into the vagina to examine the tissue between rectum and vagina. Rather than inserting the fingers straight on, he and the GTAs discovered that a horse-shoe shaped motion was more comfortable. Charles and the GTAs learned about physical stance for performing the bimanual exam, which involves inserting two fingers into the vagina to examine the cervix, uterus, and ovaries. Standing too close or too far away makes the exam difficult and emotionally uncomfortable for the patient, while tucking the elbow at the side and extending through the wrist makes it more physically comfortable for the physician and allows for better leverage.

The GTAs were encouraged to adjust the speculum in the teaching encounter so that students would learn how to properly insert it. They learned to pair this instruction on exam skills with instruction on proper communication, all with the goal of reducing student anxiety to make the exam a better experience for patients. Charles explained: "The teaching wasn't just the exam, but they [would] talk about how they [the students] were feeling and . . . if you make a mistake don't worry about it. We're trained so well . . . you can't hurt us." Thus, reassembling the exam was not only about developing manual or technical practice. It was also about acknowledging medical students' own emotional states, so that they could be examined and set aside or cultivated appropriately for professional practice. Anxiety in particular had to be managed so that medical students could appear to be confident and composed for the patient's sake, no matter how they actually felt. In this way, the GTA program also aligned with a larger movement in medical education at

the time to redefine professionalism to include acknowledgment and management of emotion, both patient and physician.[18]

The program demonstrated success. According to Charles, "The administration liked the way the students came out, liked the way they felt about themselves, what they perceived their skills to be and the feedback from [their preceptors] was they're better at it." However, Charles experienced resistance from "the family doctors, some of the internists and others": "They were terrified there were going to be affairs, there was going to be sexual activity." Some faculty members expressed concerns that paying women to receive pelvic exams was unethical and akin to prostitution. Their concerns echo those expressed in some of the literature at the time, that no "normal" woman would allow herself to be examined by strangers in this manner (Kapsalis 1997). Indeed, scholars of the pedagogical practice of the pelvic exam have pointed out the tenuous borders between shame and pleasure that exist when a person's vagina is put on display in this way (Bell 2009). Charles defended his GTAs as being skilled educators—as they were: these early GTAs developed a unique stock of bodily knowledge that qualified them as experts. The systematic valuing of GTAs' bodily knowledge as the program became more institutionalized challenged what could count as expertise in medical education. This reassembled what kinds of knowledge counted as legitimate in biomedicine and who might be authorized to teach this knowledge to neophytes in the profession.

Working together, Charles and these early GTAs dismantled, interrogated, and refashioned multiple elements of the pelvic exam. GTAs practiced insertion techniques and the bimanual exam on one another in order to learn how to teach it. In the process, Charles learned about more appropriate and more comfortable techniques, which he incorporated into the protocol. Thus, *the manual and technical technique* of the pelvic exam was reassembled through the development of the GTA program. Charles and the GTAs also focused on language and communication during the exam, removing words and phrases that were sexist, demeaning, or otherwise offensive. They incorporated ways to inform the patient about the exam as it was being performed, such as showing the patient the speculum and explaining its purpose. In this way, not only was the *language of the pelvic exam* reassembled, but

the *relationship between physician and patient* was reassembled as well. The docile patient was replaced with a more informed one. Finally, by focusing on the feelings of the medical students and by talking about how sensitive and sexually charged this exam can be, Charles and the GTAs he worked with were attempting to change medical students' own perceptions and attitudes toward learning the pelvic exam so that they felt safe acknowledging their embarrassment, discomfort, and fear of failure or hurting the patient. The *affect of the medical student* was reassembled. These changes were all related to critiques that feminist activists had of teaching and learning the pelvic exam, and many of these techniques came from the GTAs' experiences working in feminist self-help. In this way, feminists were able to bring some of the movement's practices of care into medical education.

What is a "Good" Pelvic Exam? The Development of the Protocol

During the late 1980s, as medical education developed a distinct regime of expertise, the GTA session was shaped by standardizing and institutionalizing forces. This occurred at the national level and played out on the ground at UIC. As the GTA program at UIC developed, two faculty members in the Office of Research in Medical Education were brought in to evaluate it. Their involvement came as the program had become somewhat established and attention shifted toward standardizing the curriculum. A key technology in this process was the communication checklist, which is a standardized method of teaching and assessing physician-patient interaction skills.

Elaine, a faculty member with a sciences PhD, adapted her work on such a checklist for the GTA program: "So in the checklist was . . . how you introduce yourself to the patient, how you approach the patient with comfort and modesty and all those things. . . . The GTAs were told about the expectations for . . . what a good exam would be so that they would know what to provide feedback." The GTAs were given this checklist in order to adapt their teaching styles to it and to use it in evaluating each medical student at the end of the session. The goal of standardizing the curriculum was twofold: it made certain that medical students were being taught *and* evaluated consistently, according to Elaine:

> Having a standardized checklist [is important] so that you could get some consistency. . . . The ability to say, okay, this is what we all agree on as a good exam . . . here is what the steps should look like . . . so that when their students are evaluated, they're all evaluated according to the same criteria.

Thus, developing a protocol that could be consistently taught to all medical students *and* used to evaluate them meant a certain amount of durability and concretizing of what officially counts as a good pelvic exam through the GTA session. This brought feminist politicization into clinical practice as a matter of best practices in medical education. Many of the tenets of feminist practice became cornerstones of the checklist: respecting the patient's bodily autonomy, actively involving the patient in the exam, and using language that was not derogatory or distancing (for examples of these checklists, see appendix B). Moreover, these tenets remain fundamental in GTA programs across the United States. My interviews with current and former GTAs reveal that the curriculum has remained largely unchanged since the late 1980s or early 1990s when the checklist was adopted. However, standardizing the protocol had consequences for how explicitly political the program could be.

Nancy, a faculty member with a social sciences PhD, also worked on the checklist. She identified another area of concern for the program.

> We had problems . . . in trying to diversify along racial and ethnic lines. The women for the program . . . were . . . mainly white women, and we had a little bit of diversity but we found it difficult to get the kind of diversity . . . that would really represent the patient population at [the] hospital.

Given the recruitment strategies for GTAs—coming through feminist organizations and word-of-mouth—the internal composition of the group was fairly homogenous. According to Nancy, faculty members "tried to do outreach to different communities and so forth," including reaching out to a Latina feminist organization, but ran into challenges. In our interview, Nancy cites "cultural taboos" on receiving pelvic exams from men physicians as a reason, alongside the internal homogeneity of GTAs' social groups. She identified the racial politics of different feminist

orientations toward working in or against institutions that I discussed earlier: "The women that were most motivated because they wanted to improve women's health tended to be white, probably well-educated women." Changes within the program to emphasize the professionalization of GTAs also likely exacerbated these challenges.

According to Donna, a GTA during the late 1980s: "There was a real push to, you know, make the whole thing more professional, to bring it up to a certain level." The GTAs working at the time were used to a more relaxed style of practice that was common in feminist self-help circles. Tardiness and flexibility of work schedules, as well as wearing casual clothing, had been typical for the GTAs. Then the coordinator insisted that GTAs show up to work on time and begin to dress more professionally (which meant no ripped or dirty clothing, which mattered at the time because GTAs first greeted their students fully clothed before stepping out to change into a hospital gown). This coordinator also began to more heavily emphasize offering constructive criticism to students and adhering to the standardized curriculum that had been developed, rather than going "off script" by talking about whatever the GTA felt was important. This push to "make the whole thing more professional" signaled a radical shift in the GTA program. As it became more subsumed under medical education, its earlier elements of feminist rebellion had to be shaken off. This created a great deal of political tension in the program.

Around this time, this coordinator left and was replaced by another coordinator who was even more insistent on adhering to these changes. It is unclear whether this shift was intentional or the result of individual preferences on the part of the new coordinator, who had also been a GTA. She refused to allow GTAs to discuss topics such as abortion rights and access to contraceptives, which she thought were too political. In addition, she disallowed GTAs from teaching while menstruating. The coordinator, whom I interviewed, felt that medical students were already nervous enough and confronting a menstruating body would make the encounter too anxiety-provoking, thus inhibiting their ability to learn. This prohibition became a politically charged issue for some of the GTAs. Sylvia told me:

> There was one coordinator that I just would not work with . . . because she would not allow GTAs to work if they were menstruating . . . she just had a very medical approach. . . . She would come back during the training sessions for us and report that, oh, a student had said that we were too feminist. . . . She just didn't come from the women's health perspective.

For these GTAs, menstruation was a natural function of the body and teaching while menstruating was important in order to foster that recognition and its value in medical students. Most GTAs preferred not to teach while menstruating, as it could be messy and uncomfortable for them.[19] However, being prohibited from teaching while menstruating became, for some GTAs, an issue of political concern, as it removed the choice from the individual GTA and made it a policy of the GTA program.

These contestations intensified as the program shifted more fully away from feminist control and into medical education, since practices had to align with the standards and values of the institution. Coordinators began to emphasize supporting students' education over espousing feminist politics of care. According to Jaclyn, a GTA at this time, "It went from there being a coordinator who felt like she was coming at it partly from an activist position to a coordinator who was much more about . . . we're tools of the institution and we need to do everything exactly how they say and that's how it needs to be done." This led to a crisis within the GTA working group about the politics of the program and who really controlled the curriculum. Sylvia told me:

> It was outrageous and I really thought that . . . we really needed to unionize and really become more professional in our own right . . . so that we could be stronger in terms of the curriculum and the education program. . . . We essentially had no control over that. We had control over what we did in the room once the students got there, but no control over what . . . they had been told before they came into the room.

Sylvia and GTAs like her echoed the feminist politics of the 1970s, drawing on socialist feminist notions of workers' rights to describe their work. The GTAs who espoused this position seem to have been mainly those who had come to the program through the Emma Goldman Health Center and had worked with the original group of medical students. The GTAs who had come from a network of activists working at

Planned Parenthood were less outraged by the prohibition. Donna, who came in through a friend just a little bit after Sylvia, gave a slightly different account of the situation:

> They wanted to own the program . . . They were invited in by the medical students, but it . . . became so successful . . . the Emma Goldman people decided that—they went after [Charles]. Some of them didn't like him and they thought that he was, you know, anti-feminist or something weird like that. . . . They tried to like get everybody to go on strike and not go to work. And the thing was that it paid so well that . . . most of the women that were doing it were doing it for the pay and not for a political purpose anymore.

The language of unionization and going on strike speaks directly to feminist politics of the 1970s. Campaigns such as Wages for Housework mobilized strikes and anti-work tactics to underscore women's reproductive labor (Cox and Federici 1976; Weeks 2011). Likewise, sex workers have also used strikes as tactics (Smith and Mac 2018). However, according to Donna and Sylvia, this attempted reassertion of power ultimately backfired, and the GTAs who had supported it chose to leave the program. The GTA program had become too depoliticized to make these tactics successful. Explicit feminist politics were no longer welcome.[20]

While many GTAs nationwide continue to actively maintain a feminist orientation to their work, some of the Chicago-area GTAs who have been working since the 1980s expressed to me, either formally or informally, frustration with a loss of politics from the program. Emphasizing the history of the physician-patient relationship and training medical students to respect their patients has been deemphasized in favor of making the encounter more about reducing the anxiety of medical students. GTA Vivian told me, "As it's [the GTA program] evolved, I think less and less of [the] feminist movement of, you know, address me as an equal. It's not about that. It's about the anatomy. It's not about being respected as a female. I think that's a forgone conclusion at this point." This transformation is part of the broader shift in the affective economy of medical education as faculty have begun to differently value the emotional experiences of students. According to Martha, a program coordinator:

> Medical student started having groups where they actually talked about how they felt about cutting up dead bodies and . . . things changed, sort of like the women's movement, you know. We no longer have to fight so hard, I think, and some things are just accepted and taken for-granted and part of this society. And so then it became more about just how to make it a more comfortable experience . . . for the women you're examining.

Sally, the medical student who helped found the GTA program at UIC, reflected:

> I think the historical underpinnings of a feminist basis for it are completely lost. I think now it's just all about education. And that's not wrong. But I think there's something to be learned from a notion that, you know, the common perception was that we [physicians] were uncaring . . . and not thoughtful in [our] approach to how to conduct a reproductive health exam. So I think the program brought about a change in sensibility and cultural awareness.

According to Sally, the explicit feminism of the exam has been lost, but its aims were met by bringing about transformation in the way physicians relate to their patients and perform the pelvic exam. In this way, as feminist practices were brought into medical education, only some aspects of feminist care were palatable to the institution and to GTAs themselves. Making medical students more comfortable in order to improve their educational experience was acceptable, while confronting power relations and hierarchies in medicine was not.[21]

The result for teaching and learning the pelvic exam was a declining significance in the politics of care in US medical education. A number of forces that made affect a problem to be managed declined, and the rise of medical education as an academic discipline meant a form of expertise that could more effectively "govern at arms' length" (Rose 1993) through managing affect. The US Women's Health Movement has waned. At the same time, the gender composition of medical students has become more equal. By 1993, women made up 40 percent of medical students, and by 2005, 48.5 percent (AAMC 2016). During the 1990s, a number of courses and working groups were developed to address medical students' emotions in relationship to doing physical exams.

Consumerist pressures led to a radical transformation in professional practices, as clinical medicine moved from being physician-centered to patient-centered (Clarke et al. 2003; Laine and Davidoff 1996). The culture around informed consent and patients' rights changed with the emergence of biomedicalization: patients are more informed and proactive in general, and physicians are more mindful of the patient experience for a number of reasons. Thus, a new regime emerged as medicine developed expertise in managing the threat of affect more effectively.

Instrumentality and the Politics of Care

The standardization of the "good" pelvic exam in the GTA session mapped onto national-level transformations in medical education. As I discuss in the next chapter, the development of checklists and simulated patients aligned with the increasingly science-oriented nature of medicine. Charles and his colleagues gathered data on medical student performance and anxiety before and after the GTA session, and they published several articles in medical journals. Their research added to a growing body of literature on GTA programs, as these types of programs gained widespread acceptance. In 1985, 77 percent of medical schools in the United States and Canada used GTA programs (Beckmann et al. 1985). This number remained unchanged until 1992 (Beckmann et al. 1992). This diffusion of GTA programs into the routine practices of medical schools demonstrates both the institutionalization of these programs, which remains relatively unchanged today (Dugoff et al. 2016), and aligns with other analyses of how elements of the Women's Health Movement have been coopted by biomedicine (Ruzek and Becker 1999; Thomas and Zimmerman 2007).

The cooptation of feminist practices leads me back to a critical analysis of the politics of care present in the pelvic exam. Certainly, the pelvic exam has been reassembled in many key ways as feminist politics of care were appropriated by medical education. And yet, I "unsettle care" (Murphy 2015) to fully understand the ramifications. I believe it is possible to hold space for both the positive ways in which feminist principles of care have transformed the pelvic exam at the same time that I acknowledge the exclusions and limitations. While I will return to these tensions throughout the book as I discuss new strategies of governance in medical education that rely on the modification of affect, I highlight several of them now.

One tension involves the relationship between feminism and the economic interests of the medical profession. The Women's Health Movement and the growing number of alternatives to mainstream medicine, such as self-help clinics, provided a direct economic challenge to medicine (Thomas and Zimmerman 2007). This is related to a whole host of transformations in the political economy of health care at the same time, encapsulated by discussions of consumerism in medicine (Tomes 2016). Moreover, with a growing public distrust of experts of all kinds in the 1970s (Frickel and Moore 2006), medicine *had* to listen to the activists of the Women's Health Movement in order to get their share of the market back. In this way, the practices of care that feminists espoused were assembled into medicine under the wholesale shift from physician-centered to patient-centered practices. Physicians had to learn new ways to not just care for but also care *about* patients as patients increasingly shopped around for their healthcare. In this configuration of the politics of care, the cooptation of feminist practices of care have made the exercise of medical authority more palatable to patients *in order to* bolster the economic interests of medicine (Vinson 2016). Two excellent examples of this development come from Charles's observation that style of practice in the pelvic exam was linked to the kind of information that a physician could get back from a patient and his conversations with GTAs about what exactly women did not like about gynecologists. In this way, medical education research was able to render feminist practices of care into techniques for assuring the trust and compliance of patients.

A second tension involves how feminist practices of care have translated into research on medical education. Affect must be translated from experience into language in order to be knowable to science. In a similar way, because the use of simulation allowed medical education to coopt feminist practices of care, these practices had to be rendered into something standardized, objective, and measurable. Feminist self-help was especially amenable to this kind of cooptation because it had politicized the technical details of the pelvic exam. This occurred at the same time as a movement in medical education toward standardized evaluations of medical student performance (rather than just knowledge). Feminist

practices of care that could be distilled down to measurable behaviors could be incorporated into teaching and learning the pelvic exam, while those that were more relational or that targeted structures of healthcare (such as access or control) could not and were left by the wayside. This is evident in the first checklists: behaviors and attitudes could be incorporated, while innovations such as the Pelvic Teaching Program's third protocol could not. What could be standardized could be coopted.

A third tension centers on who is being cared *for* in teaching and learning the pelvic exam. Ostensibly, the GTA program arose in response to medical mistreatment of patients. And yet, as the program continued, it lost its political teeth. It became much more of a program about tending to the emotional experiences of medical students. This is evident in Ruth's language about getting into "the eye of the storm" and teaching "these motherfuckers" the right way to treat women and Jaclyn's concerns about becoming "tools of the institution." Feminist practices of care are very much about relationality and extending empathy and compassion to both participants in the pelvic exam. As the program was distilled down to checklists and measurements, the care for the patient that had animated GTAs' work mutated into caring for medical students. This is not to say that medicine should revive its old practices of crushing the emotional experiences of medical students under the cultural mandate of detached concern. Rather, it is to invoke concern for the gendered nature of this work. The emergence of feminist practices of care were tied to critiques about the devaluing of feminized labor. And while GTAs have been able to stake a claim for compensation for their bodily knowledge, there is something notable about the labor they perform of *taking care of* medical students during this emotionally fraught encounter. This underscores how the work that GTAs do involves a great deal of emotional labor, which I discuss in chapters 3 and 4.

Fourth, and finally, the practices of care ultimately adopted in teaching and learning the pelvic exam attended to the concerns of some types of people and not others. The kinds of feminist ideologies that found working within institutions acceptable tended to center the concerns of women who were willing and able to submit themselves to medical authority as part of the yearly pelvic exam. Their politics of care did not encompass questions of access or the racialized politics of coercive sterilization. When feminists and other radical health activists did

challenge the capitalist and white supremacist underpinnings of reproductive healthcare, they were locked out of the institution or else chose to work elsewhere to expand access and knowledge to the communities most affected. The consequences of this kind of political and ideological division meant that only forms of feminist protest that aligned with the larger goals of biomedicine were coopted. As a result, teaching and learning the pelvic exam follows along the lines of the immediate concerns of making patients comfortable and compliant with medical authority.

I am deeply critical here of how care has been rendered instrumental: practices of care have become in their own way a kind of technology of affect in the pelvic exam. Yes, patients are cared *about* now, not just cared *for*, and yet these forms of care are uneven in their application and in their effects. I will never want us to return to the days when a woman is selected from a clinic to become an "anonymous vagina" to be probed by novice medical students, but I am also concerned by the ways that making the pelvic exam less frightening are entangled with capitalism and medical authority. I argue that medical education is increasingly organized around technologies of affect and forms of affective governance that seek to harness, modify, and, ultimately, make profit out of embodied capacities to feel. I consider more fully how simulation is a key technology of affect in this new regime in the next chapter.